World Vision Relief & Development Inc.

WORLD VISION / UGANDA
FINAL EVALUATION
BUNDIBUGYO CHILD SURVIVAL PROJECT
BUNDIBUGYO DISTRICT, UGANDA

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Child Survival Grants Program
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LIST OF ABBREMATIONS

ADP	Area Development Project
ARI	Acute Respiratory Infection
CDD	Control of Diarrhea1 Diseases
CHW	Community Health Worker
CSP	Child Survival Project
DIP	Detailed Implementation Plan
EPI	Expanded Program on Immunizations
GTZ	German Development Agency
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
IGA	Income Generating Activity
LC	Local Council
KPC	Knowledge, Practice and Coverage
MOH	Ministry of Health
NGO	Non-governmental Organization
PAP	Program to Alleviate Poverty
PVO	Private Voluntary Organization
TBA	Traditional Birth Attendant
TT	Tetanus toxoid
UNICEF	United Nations Children's Fund
UNDP	United Nations Development Program
USAID	United States Agency for International Development
VHC	Village Health Committee
VIP	Ventilated Improved Pit Latrine
WHO	World Health Organization

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Executive Summary

The final evaluation of the Bundibugyo Child Survival project was carried out in two parts: a KPC survey conducted by World Vision staff and community members of Bundibugyo, and a qualitative component carried out by an outside consultant from the United States, two Ugandan nationals, a member of World Vision/Washington staff and a member of World Vision/Uganda staff. The team spent three days in the field and four days in Kampala contacting more than 70 people to obtain the information for this report. Information was also gathered from reports prepared earlier by project staff.

Data from the KPC survey indicates that of the 15 objectives, the project surpassed 11, two were slightly below end-of-term target, and two were considerably below end-of-term target (see Table 2.) Reasons given for not meeting one of the immunization coverage objective include periodic shortages of the vaccines, the conditions of the roads (especially during the rainy season when transport becomes impossible), the influx of immigrants from Zaire, problems with vehicles and security issues. The project's accomplishments, however, are considerable. The evaluation team learned that World Vision's presence in Bundibugyo has dramatically changed the demography of the area - children are no longer dying resulting in larger families. Demand for health services has increased, compounds are cleaner, water sources are protected, income generating activities have been introduced and are showing results, communities recognize their responsibility to be involved, and local leaders, governmental officials and bilateral agencies all recognize and acknowledge World Vision's remarkable accomplishments in the area. Large numbers of community volunteers and health personnel have been trained over the years, and the collaboration between these groups is remarkable (see Tables 3, 4, and 5.)

The fundamental problems that brought World Vision to the area have not changed however. Bundibugyo is still one of the poorest districts in Uganda, the population continues to be largely underserved, no other NGOs are operating in the district and the conditions of the roads, which affect the transport of goods and persons remain unacceptable. The project's immunization activities will likely continue with the assistance of UNICEF and GTZ, but most of the supervisory visits and training programs will cease. A skeletal World Vision staff will, however, remain in the area to plan for a potential greater involvement in the future.

It is the opinion of the evaluating team that World Vision/Uganda can be very proud of their accomplishments, and given the hardships of the area, they have done an outstanding job mobilizing the communities, building capacity and ensuring child survival.

The evaluation team held debriefing sessions with World Vision, UNICEF, USAID, and Ministry of Health staff and shared the findings of the evaluation with them.

This report was prepared by Helga M. Morrow, Final Evaluation Team Leader.

Introduction

In September, 1989 World Vision began its Child Survival activities with USAID funding in. the Bundibugyo District in western Uganda. A one year no-cost extension was granted in 1992, and in 1993 the project was refunded when it was expanded to include the Masindi District. This final evaluation report only covers activities in the Bundibugyo District, as the Child Survival program in Masindi was granted a one year extension grant and will continue till September, 1997.

The World Vision Child Survival project has been operating in the Ntoroko county, located in the northern Bundibugyo District, which borders Zaire on the west and is isolated from the more populous Kabarole District by the Ruwenzori mountains on the east. The Bundibugyo District is one of the poorest in Uganda, partially because of its physical terrain, but mainly because of its tribal history. Historically, Bundibugyo was part of the Toro Kingdom ruled by the Batero royal family. Ethnic differences within the Kingdom resulted in marginalization and enslavement of other tribes who were largely from the Bundibugyo and the Kasese Districts. Enslavement continued throughout the colonial period and it was only after independence that the current districts were established. Today, the district remains underserved by both governmental and non-governmental organizations. This has profound implications on the availability of health services in the district, particularly with the Uganda government's current decentralized health policy, which stipulates that of all the taxes collected, 50% of all revenue can stay within the districts to cover costs. Although poor districts are supposed to receive special grants to create a greater sense of equity in the country, the trickle-down of funds has not yet occurred.

The population of the Bundibugyo District is composed of at least 40 different ethnic groups, some of whom are small-scale cultivators, while others are fishermen or nomadic cattle herders. Most of the groups are widely dispersed, and much of the terrain is inaccessible by any means other than foot. The status of women in the area is typical of the status of women in much of Africa - they carry the burden of maintaining their homes, including fetching water, caring for children and husbands, and generating income through the cultivation of fields and marketing the produce.

There are no hospitals in Ntoroko county - the nearest ones are in Fort Portal approximately a one hour drive over a rugged mountain road, and in Bundibugyo a three hours drive over an equally challenging mountainous road. There are three understaffed and undersupplied health units in the county, one in each sub-county.

The overall aim of World Vision's Bundibugyo Child Survival project was to reduce morbidity and mortality among children O-59 months of age and of women of child bearing age.

Goal of the Final Evaluation and Evaluation Team Members

As stipulated in the 1996 Final Evaluation Guidelines for CS-IX Projects, the overall goal of the Final Evaluation was to assess the impact, effectiveness and the sustainability of the Bundibugyo Child Survival project.

The team included:

Ms. Helga M. Morrow, Team Leader, Independent Consultant, USA
Dr. Larry Casazza, Director, International Health, WVRD/DC
Mr. Adoniya M. Kyeyune, Executive Secretary, Uganda Community Based Health Care Association
Ms. Florence Nangendo, Lecturer, Makerere University, Child Health and Development Center
Dr. Johnson Ngorok, CSP Project Coordinator, WVRD, Uganda

Final Evaluation Methodology

The final evaluation had two distinct phases: the quantitative phase that included the 30 cluster KPC survey, which was carried out by World Vision/Uganda before the arrival in country of the team leader, and the qualitative phase, which was carried out by the team through focus group discussions, key informant interviews, direct observation, and a review of reports and records. The KPC survey team was composed of 26 interviewers, 5 supervisors, one coordinator, and 4 support staff. They reached 270 homes with children less than 24 months of age; the exercise took 7 days. Data from the KPC survey was available for review by the team and was used to evaluate the effectiveness of some of the project's interventions. In total 376 people participated in the evaluation, including the KPC survey team and mothers interviewed.

Final Evaluation Findings

A. Project Accomplishments

"Our children are no longer dying."

--the communities served

This response was the first thought that came to the minds of most community members when asked to relate what they felt were some of the project's greatest accomplishments. Mothers, fathers and community leaders were quick to point out that the project's

immunization activities had greatly decreased the number of children that died of immunizable diseases, and that educational activities and community health policies had greatly reduced the incidence of diarrhea among infants and children. In Ntoroko community members mentioned that prior to World Vision's activities about 80 children died each year and that now they only had two deaths.

Another noticeable accomplishment according to feedback from community members was a change in the cleanliness of the villages. Community health workers trained by World Vision were able to change attitudes and practices of community members through educational and home visit activities. This mobilization had resulted in cleaner compounds, improved and protected number of water sources, rubbish disposal policies in some villages, greater use of pit latrines and better pit latrine hygiene, and improved food production. Community awareness also resulted in a change in care-seeking behavior of pregnant women and in a greater demand for premarital testing for HIV.

Communities contributed labor and supplies toward the construction of schools, health units, and concrete slabs for the protection of water sources. These community contributions were a direct result of mobilization and sensitization activities carried out by World Vision staff and by the trained community health workers and TBAs.

The local leaders and the district medical officer mentioned World Vision's response and assistance during various emergency situations in the district. World Vision was the only organization to maintain an active presence during rebel activities in the area when all other organizations removed staff for security reasons; also they responded effectively and efficiently during a cholera outbreak that killed 38 people in Ntoroko county.

"The communities have taken ownership and a political system is now in place."

--Ntoroko community leader

With increased awareness of their ability to change the behavior and practices of the members of their communities, community health workers, volunteer vaccinators and TBAs have formed an association with the intent to continue outreach activities after the Child Survival activities cease.

1.1 Accomplishments - Immunization

The immunization objectives were to increase the percent of children fully immunized and to increase the percent of mothers delivering in the past two years who have received two or more doses of tetanus toxoid vaccine. The end of term target set for fully immunized children was 75% and the final KPC survey showed a coverage of 62.5%. Although this

is slightly below the 95% confidence limit, the impact of the immunization activities are impressive, as described earlier. Reasons given for not fully meeting this objective were the nomadic nature of some of the beneficiaries, influx of immigrants from Zaire, periodic shortages of vaccines and vehicles for transport, and the incredibly poor conditions of the roads, which prevents immunization teams from reaching some of the most distant and remote areas. The end of term target for TT was also 75% and the final KPC survey showed a coverage of 72.5% - well within the 95% confidence interval for this data.

Other major inputs and activities related to immunizations, as described in the DIP include the initial training of CHWs as vaccinators, support for Ministry of Health activities at health units and through outreach programs, maintenance of the cold chain, mobilization and education of communities to participate in the immunization activities and tracing defaulters. All these activities were carried out throughout the life of the project. Outreach activities were particularly challenging as the roads were often impassable and mothers increasingly demanded the services. The evaluation team verified that communities were very much aware of the value of immunizing children, that they would continue to press for outreach immunization services for themselves and their children, and that they were willing to "fight" to maintain current level of immunization activities. One of the reasons mentioned by the CHWs that they had formed the association was to ensure that immunization activities would continue now that the project has ended. One of the negative effects of World Vision's involvement with immunization activities was that the Ministry of Health, who had previously supplied vaccines to the health units on a fairly regular basis, had withdrawn that service over the years because of World Vision's presence and the project's commitment to transport the vaccines regularly and systematically. Thus services that existed before ceased because of World Vision's initiatives.

1.2 Accomplishments - Control of Diarrhea1 Diseases

The second accomplishment of the project most mentioned by community members and leaders relates to a decrease in morbidity and mortality of children due to diarrheal diseases. Project activities included the training of CHWs in appropriate home management of diarrhea, educational messages to mothers concerning continuing and increasing breast-feeding during an diarrhea1 episode, the administration of home available fluids, the dangers of antidiarrheal, appropriate nutritional management of diarrhea, the promotion and construction of pit latrines and the protection of water sources.

The extent to which the CDD objectives were met reflects the effectiveness of the project's activities in relation to changing the behavior and practices of mothers and other community members. The end of term target for increasing the percent of mothers who continue or increase breast-feeding during an episode of diarrhea was 85% and the final KPC survey indicates that 87% of mothers follow this practice. Mothers who provided more fluids during diarrhea were reported to be 81% and the end of term target was 85%;

the use of antibiotics was decreased by 24%, exceeding the end of term target by 6%; the project exceeded by 40% the target for mothers who provide more food after a diarrhea1 episode.

Focus group discussions with community members and leaders point to the specific changes that have occurred in villages, such as covered pit latrines, cleaner drinking water and compounds that are free of human waste and garbage. The communities relate the changes in morbidity and mortality of children due to diarrhea1 diseases to changes in their practices and behavior. In Rwebisengo it was stated that before the project's presence, mothers used to give cow's milk very early to their babies and often diluted the milk with water. That practice has now largely changed - mothers know that they need to boil the water and if they have to give cow's milk, how to dilute it properly.

1.3 Accomplishments - Nutrition

The project exceeded both nutritional objectives to increase the proportion of children (O-3 months) that are exclusively breastfed by 12%, and to increase the proportion of children who are growth monitored at least annually by 8%. The project's activities focused on training CHWs to monitor the weight of children in their communities - they were provided with weighing scales - and the identification and follow-up of children that were faltering and were considered at "high risk". Mothers' education included the identification of locally available appropriate weaning foods, and methods to prepare the food.

Mothers did state that now that more children were surviving, food shortages were becoming an issue for them, making it more difficult now to adequately provide for their children's nutritional needs. Particularly, in some of the project's area, it is difficult during the rainy season to transport food supplies and because of the nature of the soil it is not possible to cultivate gardens.

There are a variety of different schemes currently in place to increase the ability of cattle herding and fishing villages members to generate more income. A milk processing and cooling plant promised during the recent elections and built in Rwebisengo is sitting idle because women are no longer willing to bring the milk to the plant as they were never able to collect any income for their produce.

1.4 Accomplishments - Maternal Care

After the mid-term KPC survey results on contraceptive prevalence were made available, there was some criticism of the validity of the data, that is, that the data did not reflect what was happening in the rest of the country. The mid-term KPC survey indicated that contraceptive prevalence in the project area was 27% and the final KPC survey supports that data, indicating that 38% of women not pregnant and not desiring anymore children

within the next two years are using a modem method of contraception.

During debriefings held with USAID and UNICEF this data was considered highly unusual, as contraceptive prevalence in the rest of the country is closer to 15%. Project staff claim that the success of their program is based on changes that were made at the health units as a result of the project's presence. Family planning is now integrated with other health services and women can more easily access these services. There is also a greater awareness among women that having many children interferes with their businesses and thus their ability to carry out income generating activities. Also the training of CHWs in family planning has led to a greater awareness in the communities of the value of child spacing.

It is not known what effect HIV/AIDS messages have on family planning practices. There certainly appears to be an awareness of condom usage and a greater demand for condoms, but whether this is strictly related to sex with casual partners or as a benefit to limit family size is unclear. Nevertheless, self-reported contraceptive prevalence appears to be well above the national average in Uganda.

The project also surpassed its maternal care objective on birth attendance by a trained TBA or professional. The end-of-term target was 85% and KPC survey data results report an 89% attendance rate. This finding was also corroborated in the focus group discussions. Interviewees stated that pregnant women were attending antenatal clinics, that TBAs were increasingly referring women diagnosed with "risk factors", and that the importance of clean and safe deliveries was well understood. The project has provided emergency transport for pregnant women with obstetrical complications, and this service is recognized as essential. It was stated that very few women now die of pregnancy-related causes, One of the midwives noted that early on in the program she personally knew of many women who had died giving birth in the villages, but that now TBAs were more aware of the need for early referral, since she started work in the area six years ago "only two women" had died. She averages 8-10 births a month at the health unit.

1.5 Accomplishments- Acute Respiratory Infections

The project surpassed the two ARI objectives with considerable margins. Baseline data shows that only 9% of mothers knew at least two signs of respiratory infections requiring referral, but the final KPC survey indicates that 76% of the mothers in the survey now know two signs. The end of term target was 40%. The project also made a commitment to train at least 80% of the health unit personnel on the WHO/ARI algorithm. By the end of the program, the project had trained 100% of the staff. Each of the Area Coordinators spends one day a week working with MOH staff in dispensaries and at Kiryandongo hospital as part of the supervisory support to strengthen ARI case management. Dispensary staff that had been trained in the WHO algorithm and were transferred to other areas were replaced with untrained staff. The project has made an effort to provide

inservice training to the new health staff. Other ARI interventions included the education of mothers regarding the prevention of ARI through environmental and domestic changes related to smoke inhalation, supplementation of health unit's stock of antibiotics in times of shortages, and the training of CHWs in case referral and home management of mild cases.

1.6 Accomplishments - HIV/AIDS

The project met the HIV/AIDS objective concerned with increasing the percent of mothers who report that they have adopted an appropriate measure to protect themselves against HIV, but it did not meet an objective dealing with increasing mothers' knowledge of three modes of HIV transmission. The means most frequently mentioned to protect themselves against infection was being faithful to one partner. There is little doubt that educational messages concerning HIV/AIDS are being heard and that behavior may be changing. One evidence of this change is a greatly increased demand for condoms and for premarital HIV testing.

The German Aid and Development Agency (GTZ) had been supplying condoms to the project at no cost, but the program is changing and a small fee will be charged in the future. One of the major complaints heard during the focus groups discussions was a chronic shortage of condoms in the district, which are distributed by CHWs. It was not clear from the discussion why these shortages occur, although it most likely caused by erratic transport availability and poor road conditions. One of the major activities related to HIV/AIDS was the training of community HIV/AIDS counselors to provide counseling services in their villages and support to AIDS patients and their families. The project has a full-time HIV/AIDS coordinator who herself provides counseling and support services to AIDS patients, counsels HIV-positive community members and is actively engaged in educational and theatrical programs for schools and other community organizations.

1.7 Accomplishments - IGAs

It was the intent of the project to provide management training to ten community-based women's groups and this goal was reached mid-way through the project. World Vision's involvement in income generating activities led to other related activities supported by other organizations. For example, the World Vision office in Bundibugyo is the disbursement agency for a governmental credit scheme *(Entadikwa)* that provides Sh lOO,OOO-800,000 to women, youth and men. The interest rate on loans is 12% and the borrower has to repay the loan within one year and must start repayment as soon as possible. The organization administrating the loan is responsible, together with the Steering Committee which is made up of local leaders, to recover the funds. Additional government funds will not be made available until 80% of the disbursed funds have been recovered. World Vision was very reluctant to accept this responsibility; however, there were no other organizations in the district qualified to take on this task.

The project is also involved in another loan scheme, the Program for the Alleviation of Poverty (PAP), which is funded by the World Bank and administrated through the Prime Minister's office. This program is strictly for people already in business who need additional funds to improve methods of operation. The interest rate is 22% and the grace period is one month. The loan must be repaid within six months. In addition, the project is involved with UNDP in the selection of community members for micro-enterprise grants. These grants are to promote income generating activities such as goat breeding, boat building and improving cattle breeding.

The evaluation team noted that the project's involvement with other organizations in IGA activities is based on World Vision's reputation in Bundibugyo and the trust these organizations place in World Vision's handling of financial and administrative matters. This is truly a noteworthy accomplishment.

2. Unintended Effects

The evaluation team in the course of its discussions identified several unintended effects. They are:

- The communities in the project area are acutely aware of the reduction in child mortality and morbidity and the fact that their families are now bigger. This positive effect also has another side; more children means that families have more mouths to feed and require more money to send their children to school. For most of the families in the target area, these problems are not easily resolved. In turn, this leads to the recognition that **Child Survival alone is not adequate and projects such as the Bundibugyo Child Survival project must expand to include integrated child development programs.** Child spacing programs are slower to show effects than typical Child Survival activities, and the consequences of saving children's lives without further concern for their well-being need to be urgently addressed.

- Awareness of the importance of nutrition for children led to a greater demand for nutritious foods. However, food security is a problem, especially during the rainy season when many of the roads become impassable. Thus supplies frequently do not meet the newly created demands.

- Greater awareness of the spread of HIV led to the closing of discos, usually held after market days. It was noted by community leaders that people attending the discos tended to participate in high-risk behavior and they felt it would be wise to reduce those opportunities

- Male CHWs were not eligible for IGA funding, and felt this policy discriminated against them. The DIP guidelines stipulate that the loans are only available for mothers with children less than two years of age.

- Greater awareness of HIV infection led to a greater demand for condoms, but the supplies did not meet the demands. Neither could the services and supplies meet the increased demand for HIV testing and for drugs to treat opportunistic infections among AIDS patients, hindering some of the positive effects of the project's effective HIV/AIDS program. The communities sought out the AIDS counselors for these services because of their assured confidentiality.

- The project's long history in the area created a sense of permanency among the community leaders and Ministry of Health personnel. As the project had received a no-cost extension after the first funding cycle followed by a three-year extension thereafter, upon hearing that the project was ending no one believed that World Vision would really leave the site and terminate operations.

- Through World Vision's presence in the area, Ministry of Health personnel in the health units learned to identify with the communities, appreciate their empowerment and recognize the importance of community values. The evaluation team was told that by working with World Vision, health unit staff had learned a whole new approach to health care, something that they had not been aware of as hospital nurses.

- World Vision's support of Ministry of Health/EPI activities actually led to a gradual decrease in the commitment of the DMO to provide resources for EPI activities. The unintended effect was a created dependency that eventually led to the diminishing of an established service.

- Noting the success brought about by the Child Survival activities, men are increasingly feeling left out. They are not eligible for TT vaccine, for IGA loans, and for nutritional supplementation programs. Men believe that if they could also benefit from some of the Child Survival activities a greater impact could be made.

B. Project Expenditures

As noted in the Mid-term Evaluation (MTE) report, a budget deficit was predicted and the evaluation team made a recommendation that World Vision/Uganda take immediate action concerning the project's projected budget deficit for FY96 in terms of program activities and staffing in both project areas. The evaluation team also recommended that the project discuss with staff the steps to take to deal with the projected budget deficit for FY96 and to develop appropriate mechanisms for timely end-of-project preparations. No steps were taken in a timely fashion. As predicted, funds for the program ran out in March of 1996 and World Vision/Uganda had to scramble to find the resources to continue operations in Bundibugyo.

Staff identified very early on in the project that the grant could not cover both project

areas as outlined in the DIP. It was obvious to the staff that a $883,000 grant for two geographically separate districts could not possibly support the same intensity and number of activities as the earlier grant of $660,000 did for one district. Yet, even this early recognition did not lead to concrete changes in program staffing or reduction of inputs such as training sessions and outreach activities. It was noted in the First Annual Report that the budget would be inadequate and that measures to deal with the projected deficit would be required. No feedback on the report was received.

In addition to this constraint, in the course of the project, Uganda's currency inflated by more than 10% and the actual costs involved in operating two geographically-separated programs were grossly underestimated. A partial solution was provided by World Vision/Uganda's other sources of funding to make up any deficits. For this reason, the problem was not seen with a sense of urgency. When the budgetary crisis actually occurred in March, World Vision/Uganda's national program director had to divert funds from other sources and obtain $40,000 from WVRD to keep activities in Bundibugyo going. It is a credit to World Vision that the program activities have continued as scheduled and that the actual budget deficit has caused minimal interruptions. However, had management paid closer attention to the earlier warning, responded to staff concerns and followed up on the MTE recommendations, the crisis could have been avoided.

C. Lessons Learned

Perhaps the most important lesson learned is the recognition that Child Survival is no longer adequate under its current mandate and that it is no longer "good" enough to help children just survive. With a worldwide reported increase in childhood immunization coverage rates, an increase in access to clean water, better sanitation and educational activities to reduce diarrhea1 disease-related child and infant deaths, an increasing number of children are surviving but not thriving. It was obvious from discussions with mothers and village leaders that families are increasing due to the reduction in infant and child mortality, but that families are not better off. Indeed, it was frequently mentioned that the project had a responsibility to ensure that the surviving children have adequate access to proper nutrition and schooling. But for an increasing number of families, adequate nutrition and educational funds to send their children to school is just a dream. The time has come to focus on integrated child and family development programs and not just on Child Survival.

Communities benefitting from protracted Child Survival funding come to rely on this funding as a never-ending service, in spite of dialogue with community leaders and mothers emphasizing that the project will one day come to an end. As happened with the Bundibugyo Child Survival project, because of its past history no one believed that World Vision would actually terminate its services. When told the project was truly ending, the community replied, "But you never told us." The lesson learned is that all Child Survival projects must have a very clear phase-out period which is discussed during the proposal

writing phase and understood from the day the project starts.

Plans need to be made in collaboration with other governmental and non-governmental organizations and with the local leadership for the continuation of necessary services, and these plans should be in writing and signed by all parties involved. A gradual phase-out may be less traumatic than an abrupt one, especially if other groups are to absorb costs and personnel. As suggested by the DMO, World Vision should have planned to stay around longer to take on supervisory functions during the phase-out time.

Project staff need to be involved in the development of the proposal and the DIP, and this should be done in-country. Staff recognized early the possibility of a budget deficit, but their concerns were not adequately recognized by management. The lesson learned is that experienced field staff are more likely to have a good understanding of resource requirements than management located in the capital city or in Washington. Many PVOs are now decentralizing their management structure, which can be an important new phase for PVOs.

Effective Child Survival projects are likely to increase demand for services, goods, drugs and equipment. Unless the projects also focus activities on meeting these increased demands, the effects of the program will only be temporary and trust will erode. If Child Survival projects rely on other organizations for supplies and services, and if those supplies and services are not forthcoming, then efforts must be made to find back-up resources. Planning for this should take place during the proposal development stage. The lesson learned here is that Child Survival programs need to become more comprehensive in dealing with integrated development issues. It is not enough to create a demand, and that demand must be met beyond the timeframe of the project.

Expansion Child Survival projects are better sited in geographically contiguous areas rather than separated by long distances. It may be more difficult to transfer what was successfully implemented in one distinct area to another target area with different cultural and physical characteristics as opposed to actually starting a totally new project. Also, unless management issues such as lines of authority are clearly spelled out, problems with personnel are likely to arise. The costs of running geographically separated programs as one are more likely to be higher than managing two separate projects because of time and resources spent on travel and communications.

The success of Child Survival projects often hinges on the extent to which staff are able to work as a team. Effective Child Survival teams could serve as an important resource for other organizations and should be given the chance to work together on other projects.

Child Survival project staff can serve as an important role model for other health personnel. When Child Survival staff work closely with other health care providers, the PVO's approach to bringing health care services to the people most in need can become an

example of how staff can work with communities and empower them to advocate for improved health care services. This approach is not taught in medical and nursing schools. Thus, PVO target areas make an ideal field laboratory for medical and nursing students.

The local leadership should be made fully aware of the project's training programs and the changes such programs will bring to communities. If possible they should be included in the training as observers, since greater support is likely to given to the project activities if the leadership is involved and consulted.

People will always support a project if they are mobilized and understand its value. Once trust has been established, the community will provide back-up support.

--statement from GTZ district director

II. Project Sustainability

A. Community Participation

A major component of the Bundibugyo Child Survival project hinges on the work performed by the CHWs, the community HIV/AIDS counselors, the TBAs, the water source committees and the volunteer immunizers. These community groups have been trained and are regularly supervised, but they do not receive any remuneration for their work. When asked what they will do now that the project has ended, the majority stated that they will continue to work with their communities. Whether this will be the case in the long run remains to be seen. Nevertheless, the volunteer health workers have formed an association with an elected president. They have met and appear to be determined to continue to function even without World Vision's presence in the area. The main goal of the association is to put pressure on the Ministry of Health to continue with the outreach activities, and to prevent an erosion of immunization coverage.

In several of the sub-counties, the health units were built with the assistance of community members who volunteered labor and materials such as sand and bricks. Community members have also donated time and supplies for the protection of water sources and the construction of VIP latrines.

Community leaders have enacted special environmental policies. For example, the use of pit latrines is mandatory in some villages, and any one seen defecating in public places can be fined. They have also closed discos on market days to reduce the opportunities for high-risk sexual behavior. Rubbish must be burned in special places and compounds are kept clean. Also the removal of bushes around compounds to reduce mosquito breeding sites is promoted.

Some [redacted] escort pregnant women to the health centers and promote mothers'

compliance with antenatal regimes.

In the past, women used to wash their clothing in wells, but that practice has now stopped and is controlled by community leaders.

B. NGOs

There are no other NGOs working in Ntoroko county. However, World Vision/Uganda is contemplating the introduction of their ADP (Area Development Project) program in the Bundibugyo District. An ADP commits World Vision to stay in an area for lo-15 years. It is an integrated development program focusing on agriculture, industry, and artisan training in addition to health. Fifty thousand dollars has been set aside for Bundibugyo to start the preliminary evaluation phase, which will take one year (FY97). Actual implementation of ADP activities is not anticipated until 1998. With these plans in mind, a "skeleton" World Vision staff will remain in Bundibugyo and will continue to carry out minimal activities.

C. Ability and Willingness of Counterpart Institutions to Sustain Activities

The health activities in Bundibugyo District have to be seen in light of the major changes in health care occurring in Uganda. With the government's decentralization policy, districts can now retain 50% of the taxes collected at the District level. There still is a large gap that needs to be filled by outside donors, who at present do not seem to be aware of Bundibugyo District. Although all districts are experiencing considerable difficulties with decentralization (e.g., there is little "trickle-down" from district health offices to the sub-counties; District staff are not getting paid; shortages of essential supplies and drugs are still chronic and severe), some of the wealthier districts have experienced some improvement.

Poor districts, such as Bundibugyo, are plagued with poverty and illiteracy and lack of financial support. It is virtually impossible to generate tax-based income if the population has no income. Funds set aside by the government for poorer districts are supposed to create greater equity in the country. However, they do not reach the district; and if they do, they are not disbursed to sub-counties but rather kept for district services, such as the hospital.

No doubt, the impact has been positive and it is our wish that the effort is sustained. Our people understand this need as well.

--Bundibugyo community leader

During the discussions with the DMO, it was promised that outreach vaccination activities would continue if the funds could be found. One of the definitive outcomes of the key informant interview with him was that the DMO requested a detailed budget from World

Vision outlining activities and costs to keep essential services going. He requested that a follow-up meeting be held in the very near future and World Vision play a supervisory role in any Ministry of Health outreach activities.

The only other major donor in the district is GTZ. During the evaluation team's meeting with a GTZ official it was learned that GTZ had prepared a budget for the district in March 1996. Based on the assumption that World Vision would continue with its program, they had deliberately not set aside any funds for the areas served by World Vision. When informed that Child Survival activities were indeed ceasing, the GTZ official was very surprised and noted that had he been informed earlier GTZ would certainly have taken that into consideration in its FY97 budget proposal.

Furthermore, the official mentioned that GTZ could still absorb some costs, for example, for immunization outreach activities, i.e., providing funds for fuel, maintenance of vehicles and outreach allowances. He also requested that staff prepare an activity list and budget for some of the essential outreach services, promising that he would do all he could not to leave the area without services, He also mentioned that any GTZ resources were matched by the government of Uganda and those funds had already been designated. Finally, he noted that collaboration with World Vision had been very positive, and that GTZ would be very happy to collaborate with World Vision on future projects. One such possibility may be an IGA project that GTZ supports for AIDS widows and orphans.

UNICEF was also quite surprised that World Vision's Child Survival activities would cease in the district. Again the element of suddenness was noted. The UNICEF representative stated that she had met with the DMO a month earlier and that he had not mentioned World Vision's withdrawal from the area. She also suggested that earlier notification would have been much better because UNICEF then could have ensured that some of the activities in the area would have continued without interruptions. She noted that a letter from the DMO to the local district authorities should be written immediately, requesting UNICEF's assistance with immunization activities. Once this official request was received, UNICEF would supply some of the funds necessary to continue outreach immunization activities. Thus, it is probable that the immunization activities in the project area will continue, perhaps not with the same degree of intensity, but still on a fairly regular basis.

Lastly, the project manager in Bundibugyo noticed that water was steadily pouring from the mountains in front of World Vision's office. She made inquiries, contacted government officials and based on her initiatives, the government has awarded the sub-county Sh 54,000,000 to construct a water gravity system that will supply Karangutu and the area near the health clinic. Work on the system should start in the near future.

D. Sustainability Plan, Objectives, Steps Taken, and Outcomes

Table 1.

End of Project Objectives	Steps Taken to Date	I
20 CHWs trained as trainers	78 CHWs participated in training sessions but have not actually carried out independent training programs	Clear mobilization of community members and knowledge of EPI, CDD, HIV/AIDS, sanitation, IGAs, and ARI.
10 Women's groups implementing IGAs	All 10 women's groups have been trained and are implementing IGAs	Self-reported increase in income for families participating in IGA schemes. Greater awareness of and demand for IGAs. Demand among men to be included in IGAs.
Proportion of communities with an active VHC	Not available	
5 Water source committees formed and functioning.	2 1 water source committees were formed and are functioning.	Water sources are clean and protected. Washing has been banned from wells. Incidence of diarrhea has greatly decreased.
Community contributions	Communities contributed labor and materials for the construction of health units, wells and pit latrines.	Communities express a sense of ownership of the changes that have occurred. Communities have instituted new sanitation policies to keep villages clean.
Train all MOH staff in WHO algorithm	All staff trained.	Greater awareness of ARI and the importance of appropriate treatment and early referral.
Involvement with DMO on EPI activities	Health unit staff have participated in training sessions.	Greater awareness among health unit staff of community empowerment and participation, and greater appreciation of their contributions.

Final Evaluation Recommendations

- World Vision/Uganda's Bundibugyo CSP staff to develop for the district medical officer: 1) a budget that details the costs of resources; and 2) an outline of organizational staff required to continue outreach activities in the Bundibugyo area. This budget should be submitted to the DMO for inclusion in sub-county budgets before the end of August, 1996.

- World Vision/Uganda, in collaboration with Bundibugyo CSP staff, to develop a detailed plan of action for close-out of equipment, supplies, materials and vehicles in Bundibugyo.

- World Vision/Uganda to clarify plans for local project staff regarding future ADP activities and continuation of World Vision's interim presence in the Bundibugyo District.

- World Vision/Uganda to inform the Bundibugyo CSP staff of their employment status after September, 1996, and that staff recognition take place at the "closing" of the Child Survival project.

- World Vision/Uganda, in collaboration with 'Bundibugyo CSP staff, to develop a proposal for GTZ on Income Generating Activities for AIDS widows and orphans, and that this proposal be submitted before 30 September, 1996, to help ensure World Vision's continued presence in the Bundibugyo District.

- Bundibugyo CSP staff to develop a budget for GTZ on the cost of outreach activities in Bundibugyo and that this budget be submitted before 30 August, 1996.

- World Vision/Uganda for the Masindi Child Survival project and for all future Child Survival projects to develop a plan of action in collaboration with district authorities that includes a specific time-table for phasing out project activities, and that this plan of action become a formal agreement between World Vision and the authorities of the District Ministry of Health.

- World Vision/Uganda in the future Child Survival projects to pay special attention to the following:
    a) increase in the involvement of the DMO and local leadership staff in the development of the proposal and in the writing of the Detailed Implementation Plan;
    b) Child Survival Expansion projects only include geographically contiguous areas;
    c) include consideration of malaria intervention activities.

- Based on the documented impact of this Child Survival project, World Vision/Uganda to

consider introduction of new Child Survival projects in other under-served and needy communities.

- World Vision/Uganda to market its documented expertise in community-based primary health care to other donors and districts.

- World Vision/Uganda to integrate all Child Survival activities into other development activities and vice versa to create synergy.

- World Vision/Uganda to share with the Bundibugyo DMO UNICEF's response to the evaluation team's concerns regarding EPI services in the district after World Vision's withdrawal from the area. Namely, that UNICEF will reinstate support for immunization activities upon a specific request from the DMO to the appropriate authorities explaining the change in immunization activities in the district and what is needed to maintain the immunization coverage at current levels.